EXPANDING CONSUMER CHOICE
EXECUTIVE SUMMARY

PRINCIPLES

Choice of health plan (i.e., health insurance arrangements offered by an insurer, employer, health maintenance organization (HMO), or other managed care organization, also known as health benefits financial intermediaries) at the individual or family level is very important to a satisfactory competitive managed health care system (1) to provide a choice of doctors, (2) to maintain ongoing doctor-patient relationships, (3) to facilitate patient willingness to work with his or her doctor, (4) to improve consumer satisfaction with health plans and the health system (studies show that people with choice are more satisfied), and (5) to allow competition to discipline price.

For these reasons, every individual or family should have a choice of multiple health plans that includes a variety of HMOs, PPOs, and other plans such as is provided to state and other state agency employees participating in the California Public Employees Retirement System. Achieving the benefits of competition would also require every individual and family to have economic responsibility for premium price differences, comparative quality information, and some standardization of benefits.

CHOICE IN CALIFORNIA TODAY

In California today, more employed individuals have choice of plans than the national average, though fewer employees of small firms have choices than employees of large firms, according to KPMG Peat Marwick data. Even though Californians have greater choice of plans than the national average, fewer working Californians have access to a health plan that provides unlimited choice of doctor. In addition, where employees have a choice of plan, it is often a choice of plan model type. This is positive in that some individuals in a group might prefer, for example, an HMO, while others prefer a PPO. However, choices among plan model types may not set up a very competitive situation among health plans because individuals are less willing to switch among them than among plans of the same model type.

OBSTACLES TO CHOICE

Small employers typically offer less choice of plan than large employers because: (1) some health plans refuse to participate in multiple choice situations with small employers, (2) employers face additional administrative burden when offering multiple plans, and (3) employers prefer to offer their whole group in exchange for the best rates possible today, even though this weakens the health plan's incentive to reduce rates in the future.

PURCHASING GROUPS

One way to expand choice of plans is to expand access to purchasing groups. Purchasing groups act like sophisticated benefits managers of large corporations for multiple employers. They facilitate multiple choice of plan at the individual or family level.

The HIPC, established in 1993 through AB 1672, is a state-run purchasing group for small employers with between two and 50 employees, specifically designed to address the administrative problems small employers have in offering multiple choice. However, HIPC growth has been disappointing relative to the small group market. A variety of theories suggest ways to improve growth. In addition to the HIPC, several other public and private sector purchasing groups have formed to service certain market segments.

With existing purchasing group activity, California has more employees in purchasing groups than any other state. However, despite this activity, purchasing groups are not available in many segments of the market.

TASK FORCE RECOMMENDATIONS

While expanding consumer choice is a widely-supported goal among task force members and the public, there is little consensus about how to accomplish it.

A. Ways to Expand Choice of Plan

(1) The logical way for the State to address the problem of the lack of individual choice would be to require employers over some size (e.g., 25 employees) to offer choices, as the federal government did in 1973 through a now-expired provision of the Federal HMO Act. States, such as Maryland, have been trying to do so, but have been blocked by the federal Employee Retirement Income Security Act of 1974 (ERISA) which exempts coverage offered by self-insured employers from state regulation. Therefore, the Governor and State legislature should petition the US Congress to create a new law, like the provision of the original HMO Act, that requires employers to offer choice of plans, which may be satisfied by purchasing through a purchasing group.

(2) Today, many health plans effectively prohibit some employers, typically small employers, from offering a choice of plans by imposing minimum participation requirements. In other words, a health plan carrier can require that at least, say, 70% of an employers' employees join its plan (i.e., choose one of the products the plan offers through that employer). Health plan carriers employ this policy, in part, to protect themselves from any potential harmful effects of adverse selection within the group. However, this strategy also prevents employees of small employers from having a choice of plans. Current law (AB 1672) combats blatant use of minimum requirements for the purpose of skimming healthy enrollees by requiring health plan carriers to consistently apply their minimum participation policy.

In addition, the state should determine whether the following recommendation will cause negative consequences such as increasing prices or skimming, and if it finds no significant negative consequences, should prohibit health plan carriers serving the small group market from declining to participate in multiple choice situations by setting minimum requirements for participation in their plans (an aggregate participation requirement for all carriers offered should be permitted to protect against adverse selection). This rule should not be applied in cases where an employer selects carriers that do not offer the same product types (i.e., HMO, PPO, etc.) and where the benefits are not reasonably comparable. In addition, nothing should prohibit an employer from

offering one plan only; and nothing should prohibit a health plan from offering a higher price than it would for covering a higher proportion of an employer's group, nor from offering a higher price to a smaller group, within current rating laws.

B. Ways to Expand Purchasing Groups

One way to expand choice of plans is to expand access to purchasing groups.

(3) The State should make it a matter of public policy to facilitate and encourage the development of purchasing groups for small and medium size employers. The applicable regulatory authority should work continuously to simplify the process of and eliminate barriers to purchasing group formation. Such measures may include, but are not limited to the following special features of the HIPC that are not common to other purchasing groups: (a) some mechanism should be designed so that employers contracting with health plans through a purchasing group need not contract with each plan separately, (b) similarly, some mechanism should be designed so that health plans participating in purchasing groups can jointly file coordinated documents with the regulatory authority, rather than each plan filing separately, and (c) if an employer wants to offer a choice of plans, but one or few benefit packages, participating plans should not be required to disclose to employers and employees details of all the other benefit packages they offer.

EXPANDING CONSUMER CHOICE

I. PRINCIPLES

Choice of health plan (i.e., health insurance arrangements offered by an insurer, employer, health maintenance organization (HMO), or other managed care organizations, also known as health benefits financial intermediaries) at the individual or family level is very important to a satisfactory competitive managed health care system for several reasons.

Provide Choice of Doctors

First, the individual doctor-patient relationship is such an important and intensely personal one that most people understandably place a very high value on choice of doctor. In managed care, health insurance is usually linked to a specific limited set of doctors. Each plan contracts selectively with a panel of doctors. While many health plans contract with largely open-ended networks, to assure people that they are likely to be able to be covered for the services of the doctors they prefer, people need to be offered either a wide range of plans or health plans that have nearly all-encompassing networks. (For a discussion of all-encompassing networks, see below.)

Maintain Ongoing Doctor-Patient Relationships

Second, and related, if an individual does not have a wide choice of plans or access to a health plan with a wide network, switching plans is likely to mean switching doctors. According to a recent national survey, of those changing managed care plans, 39% had to change doctors.[1] For patients with ongoing relationships with physicians, this would mean disruption of the relationship, inconvenience and unhappiness. For physicians who have ongoing relationships with patients, switching often means a waste of extensive knowledge of the patient's condition and history. These relationships are expensive (in terms of visits, diagnostic tests, etc.) and time-consuming to replicate. In addition, preliminary studies suggest that long-standing physician-patient relationships are associated with less hospitalization and lower health care costs.[2]

Facilitate Patient Willingness to Work With Doctor

Third, it can be hard to establish a good doctor-patient relationship with a person who does not want to be there. This explains why the historic position of the original HMOs was that members should have choice of plan.

Improve Consumer Satisfaction with Health Plans and the Health System

Fourth, consumer satisfaction, with health plans and with the health system as a whole, is likely to be much higher if people have a choice of plan. Different HMOs have different operating rules, some of which will be burdensome to some, acceptable to others. For example, one HMO might require women to have a referral from their

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[1] Karen Davis and Cathy Schoen, "Managed Care, Choice, and Patient Satisfaction", New York: The Commonwealth Fund, August 1997.

[2] Linda J. Weiss and Jan Blustein, "Faithful Patients: The Effect of Long-Term Physician-Patient Relationships on the Costs and Use of Health Care by Older Americans," American Journal of Public Health, 86:1742-1747, 1996.

primary care doctor for every visit to the obstetrician-gynecologist while in another the standard practice might be for primary care physicians to make standing referrals. People with preferences will be happier with choices. Moreover, if people do not have choice of plan, market forces will not have an opportunity to force the plans with unpopular practices to change. If people are forced into a plan by an employer, they are more likely to be unhappy with the plan and, by association, with the health care system in general. Today, in California, 46% of employees do not have a choice of plan.[3] If instead, people have a menu of options and make a choice, they are more likely to accept some responsibility for that choice and to show greater tolerance if problems occur. Indeed, the Kaiser/Commonwealth National Health Insurance Survey indicates that having a choice of plans is linked to satisfaction with services, choice of physicians, and insurance plans. Those in managed care who did not have a choice of plans were almost twice as likely to be dissatisfied with their insurance plans; 22% were very or somewhat dissatisfied with their insurance plans compared to 14% of those with a choice.[4]

Adults in Managed Care Plans Ages 18-64
Somewhat or Very Dissatisfied with Plan or Patient Care

	Total	With Choice	No Choice
Insurance plan	17%	14%	22%
Choice of doctors	15%	13%	18%
Care received	14%	13%	16%

Source: Davis, Schoen, "Managed Care, Choice, and Patient Satisfaction", New York: The Commonwealth Fund, August 1997.

Allow Competition to Discipline Price

Fifth, for competition to work to discipline price, demand for health insurance must be price elastic, i.e. if a seller lowers price by X%, she must attract more than an X% increase in the number of customers to offset the revenue loss associated with lowering price. Price elastic demand requires individual choice of plan. If there is only group choice of plan, the whole group must be persuaded to change plans to take advantage of a lower price offered by another plan. Some members of the group are likely to have strong doctor-patient relationships and be unwilling to change (unless the new plan offers the same doctors, which can happen). If there is individual choice of plan, those individuals who are willing to change for better value can do so, and make it worthwhile for the competitor to lower price. A key component to making this strategy work to create price-elastic demand is economic responsibility of the individuals making the choices for premium price differences. In addition, standardization of benefits and comparative quality information helps to facilitate choices by making it easier to compare alternatives.

[3] Kelly Hunt, KPMG Peat Marwick, Analysis conducted for the California Managed Care Improvement Task Force, Tysons Corner, VA: 1996.
[4] Davis, Schoen, 1997.

Alternatively, there could be price-elastic demand with group choice if the choices available were among plans with similar, broad networks of providers, as is the case among many plans in California today. On average, physicians in California contract with 15 managed care plans.[5] The principal basis upon which to choose a plan under these circumstances would be price because people would not have to change doctors when they changed plan. In this case, it would be easier to change plan to get better value. The trouble with this model is that it does not create price competition among medical groups where most decisions about spending are made and thus with which the potential for cost savings lie. In this model, a medical group cannot attract more customers by cutting price. This mitigates pressure on medical groups to hold down costs. Moreover, if the health plan must try to be all-inclusive, then by definition it will include inefficient as well as efficient doctors. The need to be all-encompassing weakens a health plan's ability to select physicians based on quality and to conduct value-based contract negotiations.

For these reasons, every individual or family should have a choice of multiple health plans that includes a variety of HMOs, PPOs, and other plans such as is provided to state and other state agency employees participating in the California Public Employees Retirement System. Achieving the full benefits of competition would also require every individual and family to bear some economic responsibility for premium price differences, to interpret comparative quality information, and to choose among reasonably standardized benefits.

There is a tension between standardization of benefits to facilitate comparison and wide product choice. Complete standardization would most simplify comparison, but would eliminate product choice and would block innovation. On the other hand, no standardization would allow wide choice of products, but would make plan comparison more difficult. In addition, where products compete, less restrictive plans (e.g., PPOs and POS plans) suffer from adverse risk selection (i.e., sicker people choose them to ensure they can obtain care from out-of-network specialists, causing prices to escalate). Risk adjustment can level the playing field. However, the greater the variation among plans, the more difficult it is to risk adjust.

II. CHOICE IN CALIFORNIA TODAY

California's record with regard to individual choice of plan is mixed. Of the working population in California whose employers provide health care coverage, 54.5% of employees have a choice of two or more plans. In comparison, only 48.2% of employees nationally have a choice of plans. This implies that California is doing slightly better than average in providing choice of plans to consumers.

Choice of Plans Offered - California, 1996

	1 to 49 employees	50 to 199 employees	200 to 999 employees	1,000 or more employees	Total

[5] American Medical Association, "Number of Managed Care Contracts per Practice, 1996", *Physician Marketplace Statistics, 1996.* Nationwide, physicians have an average of 11.2 managed care contracts.

One Plan Offered	66.4%	42.0%	21.9%	7.1%	45.5%
Two Plans Offered	29.9%	45.2%	38.9%	13.6%	31.5%
Three or More Plans Offered	3.7%	12.9%	39.3%	79.2%	23.0%
	100%	100%	100%	100%	100%

Choice of Plans Offered - Nationwide, 1996

	1 to 49 employees	50 to 199 employees	200 to 999 employees	1,000 or more employees	Total
One Plan Offered	83.0%	67.4%	47.4%	13.0%	51.8%
Two Plans Offered	12.9%	24.4%	24.6%	14.3%	15.8%
Three or More Plans Offered	4.1%	8.2%	28.0%	72.7%	32.4%
	100%	100%	100%	100%	100%

Source: Kelly Hunt, KPMG Peat Marwick, Tysons Corner, VA, 1996.

The 1997 Kaiser/Commonwealth National Health Insurance Survey notes that, for families, choice of plans may occur through one's own employer, through one's spouse's employer, or a combination. Taking into account options through both spouse's employers would increase the proportion with choices. By this method the Kaiser/Commonwealth survey found that 52% of all adults age 18 to 64 in working families have a choice of two or more plans compared to 36% with choices through their own employer.[6]

Those with no choice of plan are more likely to be working for smaller employers. In California 66.4% of employers with fewer than 50 employees offered no choice of plan, compared with just 7.1% of employers with 1000 or more employees. However, more than half of the working population in California work in small groups with between one and 49 employees. This is slightly higher than the national average. Small employment groups are important because they are more likely than large employers to have difficulty offering a choice of health plan and health care coverage at all.

Percentage of Employees by Size of Employer - California and Nationwide, 1996

	1 to 49 employees	50 to 199 employees	200 to 999 employees	1,000 or more employees	Total
California	51.0%	18.1%	10.5%	20.5%	100.1%
Nationwide	46.9%	9.1%	9.5%	34.5%	100.0%

Source: Kelly Hunt, KPMG Peat Marwick, Tysons Corner, VA, 1996.

Even though Californians have greater choice of plans than the national average, fewer working Californians have access to a health plan that provides unlimited choice of

[6] Davis, Schoen, 1997.

doctor. More than a quarter of working Californians whose employer provides health care coverage have access to only an HMO with a closed-end provider panel. In contrast, only 11% of workers nationally are offered only one health plan that is a closed-end HMO.

Percentage of Covered Employees Without Choice, Offered HMO Only, as % of Total Population, California 1996

	1 to 49 employees	50 to 199 employees	200 to 999 employees	1,000 or more employees	Total
One plan only, HMO Only	34.5%	31.8%	11.7%	1.3%	25.3%
One plan only, but not HMO	31.9%	10.2%	10.2%	5.8%	20.2%
	66.4%	42.0%	21.9%	7.1%	45.5%

Percentage of Covered Employees Without Choice, Offered HMO Only, as % of Total Population, Nationwide 1996

	1 to 49 employees	50 to 199 employees	200 to 999 employees	1,000 or more employees	Total
One plan only, HMO Only	20.0%	14.9%	5.5%	1.4%	11.0%
One plan only, but not HMO	63.0%	52.5%	41.9%	11.6%	40.8%
	83.0%	67.4%	47.4%	13.0%	51.8%

Source: Kelly Hunt, KPMG Peat Marwick, Tysons Corner, VA, 1996.

In addition, where employees have a choice of plan, it is often a choice of plan model type. This is positive in that some individuals in a group might prefer, for example, an HMO, while others prefer a PPO. However, choices among plan model types may not set up a very competitive situation among health plans because individuals are less willing to switch among them than among plans of the same model type.[7] For example, if an employee has a choice of two plans, but one is an HMO with, for example, $10 copayments and one is a PPO that, for example, requires members to pay 20% of costs after a deductible, an employee who is attracted by the low cost-sharing requirements of the HMO may not be willing to incur the extra cost to select the PPO even if he or she is unhappy with the HMO's service or provider panel. In California, only 28.7% of employees whose employer provides health care coverage has a choice of more than one plan of any coverage model type (i.e., HMO, POS, PPO or FFS).

Percentage Of Employees Offered More Than One Plan of Any Plan Model Type (HMO, POS, PPO, FFS), as a Percentage of the Total Population, California 1996

[7] Royalty, Solomon, "Health Plan Choice: Price Elasticities in a Managed Competition Setting", May 1997, forthcoming.

	1 to 49 employees	50 to 199 employees	200 to 999 employees	1,000 or more employees	Total
Offered One or More Plans, but Only One of Any Plan Type	85.8%	89.2%	54.7%	19.5%	71.3%
Offered More Than One Plan, and More Than One of the Same Plan Type	14.1%	10.8%	45.3%	80.5%	28.7%

Source: Kelly Hunt, KPMG Peat Marwick, Tysons Corner, VA, 1996.

III. OBSTACLES TO CHOICE

The reasons that individuals do not have greater choice are numerous and varied.

A. Individuals

Individuals theoretically have an unlimited choice of coverage options, so long as they are willing to shop around for it and pay the market price. However, in practice their choice may be much more limited due to reasons of access (e.g., plans often will not sell individual policies to unhealthy or high risk individuals).

B. Employers

Unlike other nations and albeit with decreasing frequency even in the United States, the majority of Americans and Californians receive health insurance through their employment group. In 1973, Congress adopted the HMO Act which required most employers to offer an HMO as a choice where one was available and wanted to be offered. This ensured a choice of plans in employment settings until this aspect of the law expired on October 24, 1995.

Size of employer is an important determinant in whether employees have a choice of plan. Small employers typically offer less choice of plan than large employers, as the tables above indicate. Reasons include: (1) some health plans refuse to participate in multiple choice situations with small employers, (2) employers face additional administrative burden when offering multiple plans, and (3) employers prefer to offer their whole group to one insurer in exchange for the best rates possible. This last strategy is short-sighted. Even if an employer achieves slightly reduced premiums for the first year or even two, as soon as the contract expires, their bargaining position is greatly weakened because it is very difficult to require an entire employment group to switch plans and perhaps doctors. And, the employee dissatisfaction and potential time lost from work to establish new provider relationships are unlikely to be worth the savings.

IV. PURCHASING GROUPS

One way to expand choice of plans is to expand access to purchasing groups. Purchasing groups aggregate the buying power of many individuals or groups. In theory, they act like sophisticated benefits managers of large corporations for multiple employers. They facilitate multiple choice of plan at the individual or family level. Like large employers, purchasing groups can:

- achieve substantial economies in administration,

- set the rules to ensure equitable coverage of all persons in the sponsored group such as guaranteed issue and renewal,
- create and administer an open enrollment process,
- require individuals to bear full responsibility for premium differences,
- standardize benefit options within the group,
- provide comparative quality information,
- minimize the incentive and ability of health plans to select risks, and
- negotiate more favorable prices than could an individual employer.

A. The Health Insurance Plan of California (HIPC)

The HIPC, established in 1993 through AB 1672, is a state-run purchasing group for small employers with between two and 50 employees, specifically designed to address the administrative problems small employers have in offering multiple choice (See Attachment Two: Purchasers). After three years of operation and steady growth, the HIPC covers approximately 130,000 employees and their dependents in California. While substantial, this number is very small compared to the more than ten million Californians working in small employment groups and their families.[8]

Theories abound about the reasons behind the limited growth of the HIPC. They include: (1) insufficient or inappropriate marketing effort; (2) unsatisfactory relationship of the HIPC with brokers and agents who by law are required to offer the HIPC as a choice, but who in practice do so with minimal enthusiasm. The lack of broker/agent support was due originally to unfavorable financial terms offered to broker/agents by the HIPC, but these discrepancies have been largely ameliorated. Currently, tension seems to arise over the explicit reporting of the broker/agent fee, rather than incorporating fees into plan premiums as in the rest of the market; (3) purchasing groups are a new idea, the virtues of which may not be well appreciated or understood by many; and (4) the HIPC may offer too much choice which may be overwhelming to some.

B. Other Purchasing Groups

In addition to the HIPC, several other public and private sector purchasing groups have formed to service certain market segments. These include the California Public Employees Retirement System (CalPERS) which serves over one million public employees, retirees and their dependents, the Pacific Business Group on Health (PBGH) which serves large employers with more than 2000 employees and purchasing groups (including the HIPC and CalPERS), Benefits Alliance a newly formed purchasing group for medium-sized employers with between 50 and 5000 employees in the ten-county bay area, and California Choice, also new, which competes with the HIPC in Southern California. (See Attachment Two: Purchasers, for a more extensive description).

C. Prospects for New Purchasing Groups

[8] Estimate, based on "United States–Employees, Payroll, and Establishements, by State: 1993", *County Business Patterns*, Department of Labor, Bureau of Labor Statistics, 1993.

With existing purchasing group activity, California has more employees in purchasing groups than any other state. However, despite this activity, purchasing groups are not available in many segments of the market.

To encourage the formation of new purchasing groups and to set certain criteria to which they must comply, Senator Peace sponsored Senate Bill 1559 which was enacted in 1997. Under the new law, any purchasing group formed after the implementation of the law must be certified by the Department of Insurance. They may be either for-profit or non-profit entities, trusts, partnerships, or sole proprietorships, but no owner, officer, partner, board member, or manager of a purchasing group may be affiliated with an agent or broker. While this prevents potential abuse by agents and brokers who could exclude unhealthy groups from the purchasing group, it also eliminates those with the most knowledge and likely the greatest interest in forming purchasing groups. Also, under the new legislation, the Department of Insurance is required to make a determination concerning the application to become a purchasing group within 180 days of the application date. So far, only one purchasing group has applied for certification. This group did so voluntarily as it was already an ongoing concern and not required to do so by the legislation; its application has been pending for over one year.

TASK FORCE RECOMMENDATIONS

While expanding consumer choice is a widely-supported goal among task force members and the public, there is little consensus about how to accomplish it.

A. Ways to Expand Choice of Plan

Studies show that people with a choice of plan are more satisfied with their insurance and their doctor, and with the services they receive. Choice of plan also permits a wide choice of physicians and makes it more likely that individuals can maintain a relationship with a particular physician if their job status changes. In addition, choice of plan enables competition to work to discipline price. Recommendations include:

(1) The logical way for the State to address the problem of the lack of individual choice would be to require employers over some size (e.g., 25 employees) to offer choices, as the federal government did in 1973 through a now-expired provision of the Federal HMO Act. States, such as Maryland, have been trying to do so, but have been blocked by the federal Employee Retirement Income Security Act of 1974 (ERISA) which exempts coverage offered by self-insured employers from state regulation. Therefore, the Governor and State legislature should petition the US Congress to create a new law, like the provision of the original HMO Act, that requires employers to offer choice of plans, which may be satisfied by purchasing through a purchasing group.

(2) Today, many health plans effectively prohibit some employers, typically small employers, from offering a choice of plans by imposing minimum participation requirements. In other words, a health plan carrier can require that at least, say, 70% of an employers' employees join its plan (i.e., choose one of the products the plan offers through that employer). Health plan carriers employ this policy, in part, to protect themselves from any potential harmful effects of adverse selection within the group.

However, this strategy also prevents employees of small employers from having a choice of plans. Current law (AB 1672) combats blatant use of minimum requirements for the purpose of skimming healthy enrollees by requiring health plan carriers to consistently apply their minimum participation policy.

In addition, the state should determine whether the following recommendation will cause negative consequences such as increasing prices or skimming, and if it finds no significant negative consequences, should prohibit health plan carriers serving the small group market from declining to participate in multiple choice situations by setting minimum requirements for participation in their plans (an aggregate participation requirement for all carriers offered should be permitted to protect against adverse selection). This rule should not be applied in cases where an employer selects carriers that do not offer the same product types (i.e., HMO, PPO, etc.) and where the benefits are not reasonably comparable. In addition, nothing should prohibit an employer from offering one plan only; and nothing should prohibit a health plan from offering a higher price than it would for covering a higher proportion of an employer's group, nor from offering a higher price to a smaller group, within current rating laws.

B. Ways to Expand Purchasing Groups

One way to expand choice of plans is to expand access to purchasing groups. Recommendations include:

(3) The State should make it a matter of public policy to facilitate and encourage the development of purchasing groups for small and medium size employers. The applicable regulatory authority should work continuously to simplify the process of and eliminate barriers to purchasing group formation. Such measures may include, but are not limited to the following special features of the HIPC that are not common to other purchasing groups: (a) some mechanism should be designed so that employers contracting with health plans through a purchasing group need not contract with each plan separately, (b) similarly, some mechanism should be designed so that health plans participating in purchasing groups can jointly file coordinated documents with the regulatory authority, rather than each plan filing separately, and (c) if an employer wants to offer a choice of plans, but one or few benefit packages, participating plans should not be required to disclose to employers and employees details of all the other benefit packages they offer.